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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey conducted at your facility on November 1, 2010 to November 3, 2010, in accordance with 42 CFR Chapter IV Part 483 Requirements for Long Term Care Facilities. The census was 30 residents. The sample size was 10 sampled residents which included 1 closed record. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	F 000		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.	F 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview the facility failed to ensure confidentiality of resident's personal and clinical records.

Findings include:

Upon initial tour of the facility on the morning of 11/1/10, and periodically throughout the survey ending on the afternoon of 11/3/10, it was noted that the two computer screens at the nurses station, were left on displaying various resident's clinical information. At times the information on the screens was visible to unauthorized staff, visitors and other people.

The nurses station is centrally located, somewhat circular in design and can be approached from all sides. The computer screens at the nurses station are viewable to residents, all staff and visitors.

On the morning of 11/2/10, during four individual residents med pass observations, it was noted that the nurse on the Blue Hall would pull up a

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F 164	Continued From page 2 resident's medication record from the computer, which would be displayed on the computer screen to determine which morning medications to administer. The nurse would then prepare the medications and left the screen up as she left the nurses station to deliver the medications to the resident down the hallway. The nurse on the Pink Hall was also observed preparing meds in the same fashion, but in most instances that nurse would minimize the screen, as she prepared to leave the station, so the resident's information was not left up for others to view. It was noted that even when the screens were minimized the user remained logged on to the computer, which would allow other unauthorized users access. In an interview with the nurse on the Pink Hall, the nurse indicated that she does try to make certain to minimize the computer screen when she leaves the nurses station so that resident information remains confidential. The nurse was not sure if the computer system had an automatic time out on it, so that if she were to minimize the screen and leave for a period of time others would not have access. In a discussion and interview with the nurse on the Blue Hall, the nurse indicated she hadn't thought about the screen in the same manner as a paper record being left out with resident information.	F 164		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		

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F 226	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that 1 of 8 employees was screened with a background check as required. Findings include: A review of the personnel record of Employee #5 revealed there was no background check evidence since 2002. An interview with the employee revealed she had been told by human resources the day before that she needed to be re-screened per the five year requirement.	F 226		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure and maintain a homelike environment for the residents. Findings include: Upon initial tour of the facility on the morning of 11/1/10 and periodically throughout the survey ending on the afternoon of 11/3/10, it was noted that staff equipment and resident supplies were being stored in the common or central area which is used for resident dining, watching television	F 252		

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(TV), visiting and daily activities. The area is wide open and can easily be seen as you enter the facility.

Directly in front of the nurses station, where residents sit and at times dine, there were two portable carts for the nurse's aides computer equipment. There were two long (approximately six foot) portable tables being stored behind the big screen TV.

There were four recliners lined up in front of the TV, when the recliners were not in use the recliners were pushed up against the TV, this allowed staff more space to transfer resident's in and out of the dining area.

Six other recliners were lined up against the back wall of the dining area, while one or two of these chairs were observed being used, the chairs gave a cluttered and storage appearance to the room.

The commercial grade nutrition refrigerator and freezer, and activities' cooking stove were located in the resident's dining/common area.

It was noted during several meal observations, staff would be removing dishes, scrape off and stack plates and separate utensils into a bin located in close proximity to the tables while many residents were still eating or being assisted with their meal. It was also observed on one occasion, the halls which intersect the dining/common area were being vacuumed while residents were eating.

It was noted that as soon as one meal was finished, the tables were immediately cleaned, dressed with fresh table cloths and bibs were

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F 252	Continued From page 5 placed at each setting. When staff were asked why bibs were placed out, instead of waiting and offering them to residents at the time of the meal, staff responded it was easier and that was what they had been asked to do. The staff taking care of the tables were volunteers. While the resident's dining/TV/activities common area was used for multiple functions it was cluttered in appearance, and did not always promote a comfortable dining or TV viewing experience. On 11/2/10, in two seperate interviews with the Director of Nurses (Employee #9) and the Acitivities Director (Employee #10), both parties agreed the space in the dining/common area was limited, somewhat cluttered and the storage of equipment needed to be addressed.	F 252		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and policy review, the facility failed to ensure basic nursing practices were completed for checking of tube placement prior to administering a tube feeding for 1 of 10 residents (Resident #1), and to ensure medication narcotic counts were completed by two licensed nurses during shift change. Findings include: Feeding Tube Placement	F 281		

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F 281	Continued From page 6 On 11/2/10, at approximately 12:00 noon, an observation of Resident #1's tube feeding was observed. The Nurse (Employee #11), explained the formula was to be given by gravity feed using a syringe. As the Nurse attached the syringe to the gastrostomy tube and prepared to pour the formula into the syringe, this surveyor asked the Nurse if she was going to check the placement of the tube. The Nurse, indicated she had been told by the Surgeon who had inserted Resident #1's feeding tube, that due to the type of tube that had been used, it was not necessary to check for placement prior to administering feedings. The Nurse did not know what brand/type of tube had been used, but emphasized that it was very small (narrow). The feeding was administered over a period of 45 minutes. The Nurse indicated, in other situations she routinely checked for tube placement prior to administering a feeding. On 11/2/10, at approximately 4:00 PM, in an interview with the Director of Nursing (DON), (Employee #9), the DON reiterated that staff had been advised by the doctor (Surgeon) that checking for tube placement for Resident #1 was not necessary. The DON indicated that she thought the facility followed Lippincott's standards of practice for gastrostomy feeding. Shortly after the interview with the DON, both the DON and Surgeon (Employee #12) were interviewed together. The Surgeon explained the procedure done on Resident #1, and indicated once the tube was inserted and established (within a few weeks) it was not necessary to have to check or confirm placement of the tube prior to administering a feeding. The Surgeon further indicated it was a standard of practice not to	F 281		

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check placement once tubes were established. When the Surgeon could not provide a refence for the standards of practice in which they had been referring to, the manufactures information for the tube used for Resident #1 was requested.

Review of Resident #1's surgical procedure report, dated 3/9/10 and completed by the Surgeon, indicated Resident #1 had had progressive weight loss, some aspects of dehydration and chronic aspiration in which the resident required a gastrostomy tube placement for nutrition and hydration. The report further indicated that a 18-French 3.4 centimeter Mic-key tube/button had been placed without complication.

Review of the facility's Skilled Nursing Facility policy and procedure titled Gastric Tube Feeding, with the revised date of 7/1/93, under section III Procedures, item "C" indicated tube placement was to be confirmed; item "D" indicated to ascertain if resident had digested previous feeding by aspiration of gastric contents; and "F" indicated once tube placement was confirmed and the previous feeding had been digested then the feeding could be administered.

Review of the manufactures product information care guide titled Kimberly-Clark MIC-KEY Low-Profile Gastrostomy Feeding Tube, subsection "Feeding Through the MIC-KEY" Proper Placement indicated that before feeding to check the tube to be sure it was not clogged or displaced outside the stomach (check for tube placement), and to check for residual (formula left in the stomach).

Review of the Lippincott Williams & Wilkins

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Enteral Feeding information, provided by the DON did not address checking for tube placement.

In a final interview with the DON, the facility policy and manufactures information were discussed. The DON agreed that staff should have been checking tube placement prior to administering Resident #1's tube feedings.

Narcotic Count

On the morning of 11/2/10, between 6:40 AM and 7:00 AM, the Blue Hall nurse (Employee #11) was observed counting the narcotics in the med cart. When this surveyor approached the nurse, the nurse indicated she was doing the narcotic count by herself. The nurse indicated that usually the on coming and off going nurses do the count, and sign off on the count together, but the night nurse had needed to leave. The nurse continued to complete the narcotic count by herself. It was noted, even though the night nurse had left, there was another nurse (Pink Hall Nurse - Employee #7) on the unit that could have been called to assist.

Review of the narcotic count sign off sheet indicated the night nurse had already signed off on the narcotic count, even though they had not been present for the count.

On the morning of 11/3/10, the narcotic count observations were discussed with the facility's DON. The DON indicated the narcotic count should have been completed by two nurses, and that their signatures indicated all narcotics were accounted for and that the counts were accurate.

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F 281	Continued From page 9 Review of the facility's policy and procedure titled "Controlled Substance Count/Possession of Narcotic Key" indicated it was the facility's policy to ensure the integrity of the narcotic inventory on each unit, that the narcotics and other controlled medications were to be counted at each shift change. It also indicated after the medications were counted and the inventory sheets were to be signed. The procedure outlined the following: B. At each change of shift, it is necessary for the charge nurse leaving and the charge nurse coming on duty to count the controlled substances kept on each unit., C. After the medications are counted, the nurses will sign the log stating that the count is true and the oncoming nurse accepts the inventory as correct.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure that 1 of 10 residents received necessary care in a timely manner. (Resident #3) Findings include: Resident #3 was admitted to the facility on 3/9/09 with diagnoses including chronic obstructive	F 309		

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pulmonary disease, weakness, shortness of breath, and oxygen dependency.

On July 29 of 2010 the resident complained that a growth on his chest was enlarging and rubbing on his clothing causing pain and irritation. There was a FAX sent to the attending physician on July 29 of 2010 describing the growth as 1 inch by 1/2 inch and 1/4 inch high.

A review of the record did not indicate any physician notes on the lesion until September 3, 2010. The physician note stated: "2-3 cm lesion left chest ext slight edema theo 6.0 Lesion left chest prob needs removal."

There was no documentation of an order for scheduling removal of the lesion, biopsy of the lesion, or for consultation. A review of the nursing notes revealed that on 10/8/10 Resident #3 complained of a lump in his abdomen which had increased in size. The nurse noted the lump to be walnut sized. above his belly button. The lump was noted as painless. There was no documentation the physician was notified of the lump nor were there any further progress notes related to the lump.

On 10/19/10 the nurse noted that Resident #3 complained the growth on his chest was becoming very painful when his shirt rubbed it and would like it removed. The nurse noted the attending physician had not returned her call.

On 10/20/10 the nurse noted the physician had not returned her call regarding Resident #3.

On 10/22/10 the nurse noted the attending had not returned her call and that she would call again

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F 309	Continued From page 11 on Monday. The nurse noted that Resident #3 complained the growth on his chest hurts and sometimes he cannot stand to button his shirt. On 10/25/10 the nurse noted the physician was again notified of the growth on Resident #3's chest. On 11/2/10 Resident #3 was interviewed and he showed the surveyor the growth on his chest and described that it was tender to the touch. The nurse surveyor observed the growth and went with the facility nurse to measure the growth. The growth measured 3x2 centimeters and 1 centimeters in height. The lesion was varigated in color and red at the base. The facility failed to obtain timely treatment to address Resident #3's lesion.	F 309		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to monitor and maintain adequate weight	F 325		

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F 325	Continued From page 12 for 1 of 10 residents. (Resident #1) Findings include: Resident #1 was admitted to the facility on 9/23/09 with diagnoses including idiopathic peripheral neuropathy, joint pain, and weakness. Resident #1 was admitted for rehabilitation and a planned return home. According to the history and physical Resident #1 had lost 30 pounds (lbs) prior to her admission. The resident also had an extensive list of perceived food allergies. The resident reported she did not eat much and had no appetite. A review of the record indicate Resident #1 weighed 137 lbs. on admission. The nutritional risk assessment of 10/1/10 indicated an ideal body weight of 111-135 lbs. with a moderate risk. Weekly weights in October of 2009 revealed a steady weight loss of 8 lbs. The resident continued to deteriorate in her abilities to perform activities of daily living and ability to participate in physical therapy. The resident's pain continued to increase. According to the record Resident #1 was placed on monthly weights in November of 2009. The November weight was listed as 130 lbs. The December 2009 weight was 121 lbs. The record indicated the resident became dysphagic in February of 2010 and was placed on a dysphagic diet. The resident also lost the ability to speak around January of 2010 and there was evidence of several neurology consultations to obtain a definitive diagnosis for the resident's deteriorating condition.	F 325		

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F 325	Continued From page 13 In March of 2010 Resident #1 was diagnosed with supranuclear palsy. The diagnosis was explained to the resident and family members. The disease is progressive and the resident agreed to a feeding tube which was placed in March of 2010. The record indicated there no weights recorded from December of 2009 until May of 2010. The May 10, 2010 weight was 108 lbs. An interview with the facility dietician indicated the food service manager consulted daily with Resident #1 on food perferences and what she would eat as the resident changed her mind daily and from meal to meal as to what she would tolerate. When asked where the documentation was as to the constant resident consultations, the dietician revealed there was no documentation of the daily monitoring of the resident's intake. The resident's weight continued to decline and reached a low of 102 lbs. in August of 2010. The dietician indicated the resident was happy with her weight loss, but there is no documentation of that fact. A dietary note from 1/20/10 revealed the resident had lost 10% of her body weight over the last quarter. The dietician noted her weight appears to be leveling and is still within normal weight limits. The facility did not address Resident #1's continued weight loss to maintain acceptable weight parameters for the resident.	F 325		
F 356 SS=E	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked	F 356		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 14 by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure all required information was included in the daily posting of the nurse staffing information and to retain 18 months worth of required posting information. Findings include: The facility's nurse staffing information was posted on a plain eight by eleven (8"x 11") white sheet of paper, and was located in the upper left	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295024	A. BUILDING _____ B. WING _____	11/03/2010

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F 356	Continued From page 15 hand corner of a bulletin board adjacent to the nurses station. The staffing information was printed in a standard size font (10-12) and did not stand out among the various other postings that filled the bulletin board. The staffing information was posted for a weeks period instead of the required daily posting. The staffing information did not include the following requirements: current date, total number and actual hours worked by the various categories of licensed and unlicensed nursing staff, and the resident census. On 11/2/10, the staffing information requirements were discussed with the Director of Nursing (DON), (Employee #9). When asked to review the previous 18 months of staffing information, the DON confirmed the facility had not retained the staffing information as required.	F 356		
F 498 SS=E	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that 5 of 8 new nursing assistants demonstrated skills and competencies on hire. Findings include: A review of the personnel records of Employees	F 498		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 498	Continued From page 16 #1, #3, #4, #6, and #8 revealed there was no evidence of competency testing in the files. An interview with the director of nursing (DON) revealed there was a skills checklist the employee was to complete with the supervising nurse after employment, but that none of the above employees had turned in the checklist as required.	F 498		